

Medical Prescription for Automated External Defibrillator

This document shall serve as an official prescription and medical authorization for _____ (“Customer”) to purchase or otherwise acquire and use an FDA approved Automated External Defibrillator (AED). The Customer shall be responsible to use and maintain the AED in accordance with applicable federal, state, and local regulations and ordinances.

Customer Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Contact Person: _____

Phone Number: _____

Make/Model of AED(s): ZOLL AED Plus

Authorized Representative (Customer) Signature

Date

Print Name/Title

Authorizing Physician Information:

Physician Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

License #: _____

Authorizing Physician Signature

Date